TESTIMONY BEFORE THE PUBLIC HEALTH COMMITTEE

PUBLIC HEARING ON MARCH 14, 2022

Honorable Rep. Steinberg, Sen. Abrams, and distinguished members of the Public Health Committee:

My name is Margaret Watt. I am a resident of Norwalk, working for the past 10 years in regional behavioral health leadership positions in Southwestern CT, including launching the RBHAO for Southwestern CT and serving as Executive Director of its predecessor organization, the Regional Mental Health Board. I am also a Board member and policy chair of the CT chapter of the National Alliance on Mental Illness (NAMI CT).

Thank you all for the many bills you have put forward this session aimed at relieving some of the mental health crisis our state finds itself in. Below I am sharing thoughts on a number of bills:

CONCERN: HB5419

COMMENT: SB331, SB367, SB368

SUPPORT: HB5275, HB5395, HB5396, SB376

CONCERN: HB5419 would codify the Regional Behavioral Health Action Organizations (RBHAOs) as well as update other statutes. The revisions are intended to back-correct for changes made by DMHAS several years ago when the Agency defunded the Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs) while they were in statute. The proposed legislation would make the RBHAOs responsible for RMHB and RAC functions, including the functions of the Catchment Area Councils (CACs) which were supported by the RMHBs, despite the fact that some of these functions have already ceased.

- I am most concerned about section 4 of the bill, which removes any requirement for individuals with lived experience to be a part of the State Behavioral Health Board. The language proposed for deletion (lines 123-135) required that individuals with personal experience with mental health and substance use disorders from each of the 5 regions serve on the State Board.
    - Please understand that this representation was part of a visionary design that prioritized the "consumer" voice in behavioral health. That vision was developed in response to the discovery that patients in the state's psychiatric hospitals had been abused behind closed doors. It led to the creation of the RMHBs and CACs as entities that would empower *service recipients (as the majority voice),* families, and providers to work together to provide independent oversight of services delivered through the state-funded system.
    - To date, this level of representation has been abandoned in the creation of the RBHAOs. Removing the voice of lived experience at the State Board further represents the dismantling of the original vision. **This is a major shift in values that should be addressed by the legislature.**
    - I also note that Section 4 as edited in this bill states that there will be 19 total members of the Board, but the description adds up to 21.
- If this bill is enacted, its purpose should be to clearly delineate the guiding values, realistic priorities, and membership of the new entities (the RBHAOs), rather than to compile the old statutes into one document without addressing their complexities. In particular:
    - *Role in planning:* The statutory language from the RMHBs, if maintained as in this bill, will **call for the RBHAOs to review and approve all hospital and provider plans and grant applications in their**

regions, in conjunction with DMHAS, in ways that have not been in place for years. If this role is brought back, it will require expanded funding and staffing of the RBHAOs, and should further include a requirement for input from the people to be served. This would certainly be a valuable role when providers plan major changes in services, such as Norwalk Hospital now moving all its psych beds to Danbury.

- *Focus on prevention vs treatment and recovery:* RMHBs were primarily tasked with reviewing and making recommendations about the **mental health treatment and recovery** system, while RACs were primarily tasked with **preventing substance misuse**. The RBHAOs were given contracts that prioritize prevention and have not been adequately staffed or funded to work across the full prevention, treatment and recovery continuum. The new legislation should clarify how these roles should be balanced, with implications for future hiring, staffing levels, etc.
- *Review of services delivered:* I am pleased to see that Sections 8 and 9 preserve the CACs, including the requirement for at least 51% of their constituents to be individuals with lived experience and the requirement for the CACs to study services delivered and make recommendations. However, Section 8 maintains a requirement for the mayor/selectperson from each municipality in a region to appoint an individual to the CAC. This requirement was often problematic, resulting in open positions, positions with undefined terms, positions that were more political than appropriate, etc.

- If this bill is enacted after further editing, please ensure that it uses the most current language. Specifically: Replace "consumer" with "individual with lived experience" or "individual receiving services." Replace "substance abuse" with "substance misuse." Also note that the word "health" in "regional behavioral health action organization" is omitted at least 3 times.

COMMENT: **SB331, Section 6** requires medical providers to conduct a mental health assessment during annual physicals. This concept is important, but implementation will require time, training and resources for providers. Providers will need to be comfortable with a process of "Screening, Brief Intervention, and Referral to Treatment" (often referred to as SBIRT and used in the context of identifying people needing substance use treatment).

- The SBIRT model is a simple process and can be very brief, but each of its 3 steps is important. Currently, people do fill out mental health screenings for some medical doctors, and some report not receiving any feedback. This defeats the purpose: the patient doesn't know if their provider even looked at their results and has no opportunity to ask about getting help for themselves or a family member. **Someone in each practice (not necessarily the same medical provider) will need to be trained and have time** to provide feedback, answer questions, state clearly that treatment is available and effective, provide a warm handoff when needed, and share resources.
- Such an assessment is a critical opportunity to **screen for *both* mental health and substance use disorders.** Too often, people are screened for depression but not anxiety (although anxiety is more prevalent), or given an SBIRT for substance use but not mental health (even though they co-occur), etc. At the Southwestern Regional Mental Health Board, we identified a gap in integrated screenings and compiled an integrated screening tool (using existing evidence-based screeners) which was used in community, college and hospital settings. It can be filled out in a couple of minutes while the patient waits in the exam room and scored by the nurse or doctor in seconds. (Access the tool here.) The tool itself is less important than the concept of screening for *both* mental health and addiction. SB331 clearly seeks to integrate mental health into physical healthcare; let's not leave addiction in a separate silo.

- Please **include a requirement that posters listing the various hotlines available in CT along with 2-1-1 and regional resources such as the RBHAOs should be clearly visible** in every provider office.

COMMENT: **SB368 CT SAB** codifies the CT Suicide Advisory Board, which has been operating for years as a joint effort of DCF and DMHAS. CT SAB has provided leadership in gathering data and developing strategies, so updating the statute formerly relating to the Youth Suicide Advisory Board is important.

- Consider **adding into the proposed legislation a reference to the Regional Suicide Advisory Boards (RSABs),** which the RBHAOs were tasked with developing two years ago.
- Please note that historically there has been virtually no funding for suicide prevention in the state. CT SAB did receive a grant last year, but it is important to **annualize appropriate funding for both the state and regional advisory boards.** Currently the RBHAO where I used to work has an 18-month grant from DCF and a promised grant from DMHAS that has not been funded but would similarly be short term. If the state is serious about preventing suicide, there must be a commitment to fund the work on an ongoing basis.

COMMENT: **SB367 flavored vapes**

- Consider updating section 1 to **include a definition of nicotine that specifically identifies "synthetic nicotine" and "tobacco-free nicotine."** As reported by the New York Times last week, Big Tobacco has gotten around FDA regulations regarding sales of vape products by shifting to these other substances.
- Consider further **increasing penalties to businesses that sell to minors**. Under the proposed legislation, a vendor who sells to a minor only has to complete an educational program with *no* fine unless the program is not completed. While SB367 would increase the fine for a 2nd offense from $750 to $1500, I do not believe this is adequate to alter business practices or send a strong message. Just last month (February 2022), Norwalk police conducted compliance checks on local vendors, and 8 out of 10 failed. Most notably, for 4 of them it was the 3rd offense (a $1000 penalty under existing law, which would rise to $2000 under this amendment). In addition, **one Norwalk business was cited for the 8th time just since December 2020**. Under existing law, that business should have been fined $1000 and had its dealer registration suspended for 30 days each time, yet it appears to have resumed business as usual. Clearly the value of the underage sales makes affordable fines a simple cost of doing business.

SUPPORT: **HB5275,** section 7 of SB331, and also SB415*: It is important to remove the requirement for **step therapy** for individuals with behavioral health disorders. Step therapy requires patients to "fail first" on alternative drugs before insurers cover the drug recommended by the prescriber. Too many people have seen their mental health decompensate due to this requirement, as often reported by NAMI members and consumer advocates. *SB415 is in the Insurance & RE Committee.

SUPPORT: **HB5395** would allow **reciprocity for mental health providers with valid licenses** in other states. This will help expand the capacity of our behavioral health workforce.

Please ensure that such reciprocity would apply to any valid mental health licensure: LSCW, LMFT, LADC, etc.

SUPPORT: **HB5396** establishes a psychedelics review board. The NAMI CT public policy committee supports piloting the use of psychedelics in treatment.

It will be critical to ensure strong oversight, protocols for consent, and attention to any potential inequities in the demographics of clients receiving the treatment.

SUPPORT: **SB376** would remove funds related to **ABLE accounts** from consideration as income when determining an individual's eligibility for state assistance. ABLE accounts were created as a way for qualified individuals with developmental or psychiatric disabilities to set aside savings while still accessing state assistance for which they are eligible. This bill closes a loophole and honors that intention.

Thank you for your consideration.

Sincerely,